Southern California University of Health Sciences


☐ **CHIROPRACTIC**
☐ **ACUPUNCTURE**
☐ **INTEGRATED SCIENCE**
☐ **MASSAGE THERAPY**
☐ **AYURVEDA**

***Office of the Registrar***

# Graduation Verification Form

***PLEASE PRINT***

Name _____ Student # _____

Address _____City_____

Zip Code _____ Telephone # _____Soc Sec #_____

Signature_____ Date _____

---

**Please send Graduation Verification, with the information noted below, to:**

Name of person/organization: _____

Attention: _____

Address:_____

City: _____ State: _____ Zip/Postal Code: _____

*Check one* Mail request: _____ Fax request: _____ Pick Up request _____

---

**Please include the following information:**

_____ S. S. # _____ Enter Date _____ Grad Date _____ Birth Date _____Good Standing

---

**Please mail your request with payment to:**

SCUHS
Attention: Registrar's Office
16200 East Amber Valley Dr.
Whittier, CA 90604

**OR**

You may fax this request with the credit card authorization form to:
562-902-3306
Attention: Registrar's Office

**YOUR REQUEST WILL NOT BE PROCESSED WITHOUT VALID PROPER PAYMENT**

---

_____ $ 10 each (Alumni Request) _____ $ 20 each (Corporate Request)

Attached is: Check ____ Money Order _____ Cash _____ in the amount of: _____

---

**For use by Registrars Office:**

**Date Received: _____** **Date Mailed: _____**

**Processed By: _____** **Issued to Student: _____**

Rev5 TN